Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
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United Healthcare

OUTPATIENT TREATMENT REQUEST FORM (OTR)

Fax Request To: HPN BH, Utilization Management, 702-341-7681	**Questions/Concerns:** 702-240-8733 or 877-399-6094
Please allow 14 days for processing request. You may verify the status of your request via online provider center.	
Instructions:	**All sections marked with an asterisk (*) must be completed. Lack of information will delay the process of this form.**

Member Information

***Member Name:**	***Member ID Number:**
***Date of Birth:**	***Insurance Plan:**

Provider Information

***Group/Facility Name:**		
***Rendering Provider Name and Title:**		
***If applicable, Supervising Provider Name and Title:**		
NPI for the Provider:	***Tax ID:**	
***Address:**	***City:**	***State and Zip:**
***Telephone #:**	**Fax #:**	

Requested Services

Select One:	☐ Psychotherapy ☐ Medication Management – Office visit ☐ Substance Use Disorder ☐ Specialty Injectables – Sublocade and/or Vivitrol **only** ***CPT required below. Long acting injectables (LAI) are a pharmacy benefit. If you're requesting LAIs, click Behavioral Health Injectable Antipsychotic PA Form or go to https://www.healthplanofnevada.com/Provider/Long-Acting-Injectable-Medications.**
Select One:	☐ Initial Service Request ☐ Additional Services Request

- **Initial Services Request** – End date is determined by one (1) calendar year from start date.
- **Additional Services Request** – Clinically reviewed. End date is determined by frequency of sessions.

Select One For Initial Services Only:	☐ 1 - 90791 (Psychotherapy/Substance Use Disorder) ☐ 1 - 90792 (Medication Management) ☐ 1 – H0001 - HF (Alcohol and/or Drug Assessment) (Medicaid only)
*Start Date of Requesting Service:	*Diagnosis:

***SERVICES REQUESTED:**

CPT Code Requested:	Number of Sessions:	Frequency of Sessions:
CPT Code Requested:	Number of Sessions:	Frequency of Sessions:
CPT Code Requested:	Number of Sessions:	Frequency of Sessions:
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Member Information	
***Member Name:**	***Member ID Number:**
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Treatment Information

Prior Treatment: ☐ Yes ☐ No

Explain:

Explain: Presenting/Current Symptoms, Impairment of Function and/or Any Progress to Date:
***For SUD cases, please provide ASAM dimensions (1-6)**

Interventions and Goals:

LOCUS Score: **CALOCUS-CASII Score:** **ESCII Score:**

Signature of Rendering Provider:

***If Applicable, Signature Supervising Provider:**